Letters to the Editors

Re: "Laparoscopic assisted distal gastrectomy for early gastric cancer: five years' experience"

To the Editors:

We read with great interest the paper by Mochiki and colleagues[1] about long-term results of laparoscopic-assisted distal gastrectomy (LAGD) for early gastric cancer (EGC).

The authors retrospectively analyzed a series of 89 LAGDs and 60 open distal gastrectomies (DGs) for EGC. In the LADG group, laparoscopic D1 resection and left lymphadenectomy were associated with open Billroth I reconstruction and anterosuperior common hepatic and celiac artery lymphadenectomy performed via an epigastric 5-cm incision. In the DG patients, splenic artery lymphadenectomy also was performed. Comparing postoperative outcome and survival, no significant differences were observed in operation time (LADG 209 vs DG 200 min) and 5-year survival rate (LADG 98%, vs DG 95%). A different number of harvested nodes was noted (LADG 19 vs DG 25) and explained as a consequence of the splenic lymphadenectomy extension.

The authors concluded that LADG is a safe and useful operation for EGC, equivalent to DG in terms of mortality, long-term survival, and efficacy in preventing cancer recurrence. We agree with the conclusions of Dr Mochiki and colleagues, but we believe that laparoscopic gastric surgery for cancer has a far-extended role on the basis of our experience with total laparoscopic surgery for advanced gastric cancer (AGC).

Up to now we have performed 95 laparoscopic total (13) or subtotal (82) gastrectomies with D1 (28) or D2 (67) lymphadenectomies. Mortality rate was 5.4%; conversion rate was 3.1%. From a technical point of view, we were able to reproduce the same procedures performed with the open approach, using Billroth II or Roux-en-Y reconstruction, as needed.

From an oncologic point of view, resection margins were tumor-free and lymphadenectomy was adequate, with a large number of dissected lymph nodes. In a prospective randomized trial of open (open group [OG]) versus laparoscopic (laparoscopic group [LG]) subtotal gastrectomy for AGC,[2] we observed a similar mean number of resected lymph nodes (OG, 33.4 ± 17.4, vs LG, 30.0 ± 14.9) and similar 5-year overall and disease-free survival rates (OG, 55.7% and 54.8%, vs LG, 58.9% and 57.3%). Moreover, in a comparative study of 20 open and 20 laparoscopic subtotal gastrectomies with D2 resection, a detailed analysis of resected lymph nodes showed a similar mean number of total (OG, 53.8 ± 23.5, vs LG, 54.1 ± 16.5), perigastric (OG, 36.2 ± 13.6, vs LG, 36.8 ± 8.9), and second tier (OG, 17.6 ± 10.6, vs LG, 17.3 ± 7) lymph nodes.[3]

In conclusion, we think that the laparoscopic approach is safe and useful, and does not limit the feasibility of radical resection with extended lymphadenectomy in the treatment of AGC.

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doi:10.1016/j.surg.2005.06.020

A problematic complication of sex change operation

To the Editors:

Sex change operations have been regarded as a taboo in Japan, and many patients have undergone operation secretly or in foreign countries. Therefore, almost all complications are thought to be unreported. Recently we experienced a curious and novel complication after a sex reassignment operation that is a medical problem as well as a social issue.

A 21-year-old man who had undergone transsexual operation a month before came to us because he had lost his vaginal prosthesis, which was placed at night to prevent strictures of the vagina. He told us that the vaginal space had been created transperineally and that his scrotal and penile skin had been patched to the inner surface at another hospital. He also reported that he prostituted himself as a woman sex worker at a brothel.

On admission he complained of slight abdominal pain but no symptoms of peritoneal irritation. Computed tomography scan showed that the prosthesis had

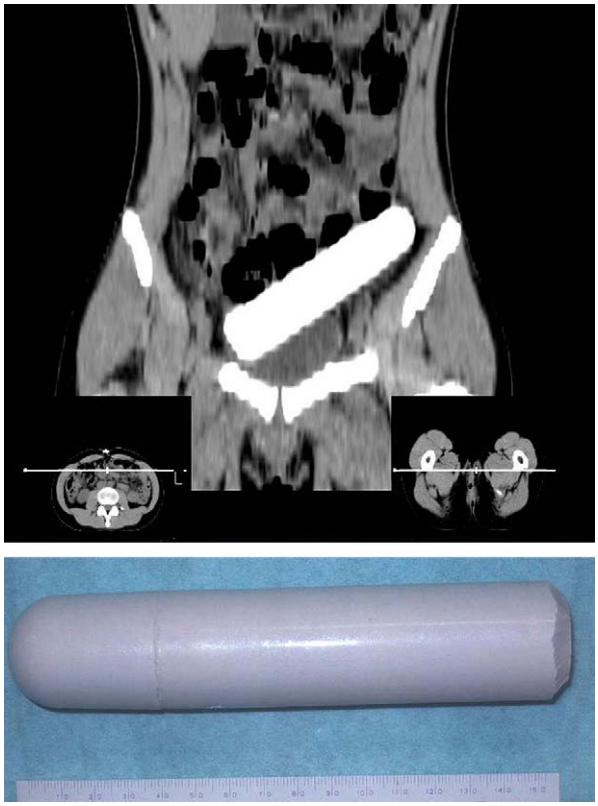

Figure. *Upper,* computed tomography scan showed the prosthesis migrated into the peritoneum. *Lower,* the removed vaginal prosthesis, made of silicone, was 14 cm long and 3 cm across.

migrated into the peritoneum (Fig, *upper*). Because he was concerned about scarring, removal was first attempted transvaginally for 4 hours without success. It was removed successfully with a 5-cm pararectal skin incision. The prosthesis, made of silicone, was 14 cm long and 3 cm across (Fig, *lower*).

In 1965 in Japan one gynecologist was arrested because he performed 3 sex reassignment operations illegally (so-called Blue Boy Case).[1] Since then, sex change operations have been regarded as a taboo in Japan, making life very difficult for people who suffer from gender dysphoria. In 1997, medical guidelines for transgender persons were issued by the Japanese Society of Psychiatry and Neurology, and in 1998, sex reassignment surgery was begun officially at Saitama Medical School.[2]

However, only a few operations have actually been performed in the few "legitimate" hospitals in Japan, and many patients still undergo operation clandestinely or in foreign countries because of the cumbersome bureaucratic procedures.[2] Under the current guidelines, it takes 2 to 3 years for a patient to complete the procedure because they are required to receive psychiatric counseling and hormone therapy while gaining ethics committees' approval.[3]

This curious and novel complication of the migration of a prosthesis into the peritoneum occurred under the current guidelines. However, we think that this represents only a small glimpse of a much larger problem and that we saw merely the tip of the iceberg.

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doi:10.1016/j.surg.2005.06.021